KAMALA D. HARRIS
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
ANTOINETTE B. CINCOTTA
Deputy Attorney General
State Bar No. 120482
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2095
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **VICTORIA REYES SANTOS** **5 Wintermist** **Irvine, CA 92604** **Registered Nurse License No. 477441** Respondent.	Case No. 2013-573 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about March 31, 1992, the Board issued Registered Nurse License Number 477441 to Victoria Reyes Santos (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

7. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY AUTHORITIES

8. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

COSTS

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUG

10. Clonazepam, generic name for Klonopin, is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(7), and is a dangerous drug pursuant to Code section 4022. Clonazepam is in a group of drugs called benzodiazepines (ben-zoe-dye-AZE-eh-peens). It affects chemicals in the brain that may become unbalanced and cause anxiety. Clonazepam is used to treat seizure disorders or panic disorder. The National Institute of Health warns: "Do not stop taking clonazepam without talking to your doctor, even if you experience side effects such as unusual changes in behavior or mood. If you suddenly stop taking clonazepam, you may experience withdrawal symptoms such as new or worsening seizures, hallucinating (seeing things or hearing voices that do not exist), changes in behavior, sweating, uncontrollable shaking of a part of your body, stomach or muscle cramps, anxiety, or difficulty falling asleep or staying asleep."[1] The National Institute of Health also warns about accidental overdose: "In case of overdose, call your local poison control center at 1-800-222-1222. If the victim has collapsed or is not breathing, call local emergency services at 911. Symptoms of overdose may include: drowsiness; confusion; coma (loss of consciousness for a period of time)."[2]

CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence, Incompetence)

11. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) in that she was grossly negligent and/or incompetent in the care and treatment of a patient. The circumstances are as follows:

12. On or about May 2, 2009, a 77 year old female presented to the Emergency Room (ER) at Orange Coast Memorial Medical Center (OCMMC), complaining of right chest pain, right shoulder pain, shortness of breath and generalized malaise. She received a cardiopulmonary workup, and was admitted to the hospital with a primary diagnosis of left lower lobe pneumonia.

[1] See, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html.
[2] See, *id.*

The patient also had a medical history of hypertension, chronic obstructive pulmonary disease, chronic bronchitis, gastroesophageal reflux disease, hypercholesterolemia and leg cramps. The patient was admitted to the Telemetry Unit on May 2, 2009, at 03:00 a.m, where Respondent was employed as a Registered Nurse II.

13. The admission orders from the physician were written on an abbreviated form titled "OCMMC Emergency Department Physician's Holding Orders" which referenced further orders on the "Pneumonia" order set. The Holding Orders included two medications: Ondansetron, and Hydromorphone. The "Pneumonia" order set was initiated by a registered nurse as a telephone order from the admitting physician at 03:35 a.m., and included IV fluid orders, and an order for a pheumonococcal vaccine.

14. On May 2, 2009, at 14:00 hours, the patient's attending physician came in, and wrote orders for antibiotics. He also signed the "Preadmission Medication List Verification and Order Form," which appears to have been filled out by nursing. It was on this order form that the order for Clonazepam (Klonopin) had been written as "Clonopin" for a dose of "2.5mg PO QDAY (Noon)." On the physician's initial progress note, he did record a list of all the patient's current medications. On this note, the dose for Clonazepam (Klonopin) is written as Klonopin, and could be read as either 0.5 mg or 2.5 mg. The dose is unclear, and should have been verified before written by nursing on the "Preadmission Medication List Verification and Order Form." However, the physician did sign this erroneous order sheet prior to any administration of this medication to the patient. The actual dose of the medication was 0.5 mg. Also, the medication was to be taken only as needed for sleep, and not every day at noon.

15. On May 2, 2009, during the day shift from 07:00 until 19:00, the patient did not receive any of her routine medications, including the Clonazepam (Klonopin). At 18:00, a nursing note was made that the Clonazepam (Klonopin), handwritten as "Clonapin," was not given as the administration time of 12:00 noon had passed, and that the medication would be started on the next day.

16. On May 3, 2009, Respondent was assigned to care for the patient on the day shift from 07:00 until 19:00. This was the first and only day that Respondent was assigned to this

patient. At 12:00, Respondent withdrew 5 tablets of Clonazepam (Klonopin) 0.5 mg each from the Pyxis, and documented that she administered 2.5 mg of Clonazepam (Klonopin) to the patient. There is no indication in Respondent's nursing notes that the patient did not take the full dose of this medication, nor did Respondent document that the patient questioned this dose amount. None of the Clonazepam was returned to the Pyxis unused or wasted. The patient reported that she never took the medication, and questioned Respondent about the dose. Respondent failed to investigate why the patient was to receive the medication or the correct dosing amount after the patient questioned the dose. This is gross negligence. An ordinarily responsible and prudent registered nurse would also question a medication dose when 5 tablets must be administered to make one dose. If there were any questions, a responsible and prudent nurse would hold the medication until it could be checked with the patient or a family member in addition to the physician. In this case, the patient was awake, alert, and oriented. Also the patient's husband was frequently present making both available to ask. If Respondent had investigated the reason that the patient was taking Clonazepam (Klonopin), the dose would have been determined as high for the purpose of "as needed for sleep." Also, the scheduling of the medication would also have been questioned, as medications for sleep are not given at 12:00 noon, and are not commonly ordered as routine but rather, as needed. Respondent's failure to determine the reason for the medication is incompetence.

17. On May 4, 2009, another registered nurse was assigned to care for the patient. This registered nurse questioned the Clonazepam (Klonopin) the 2.5 mg dose to be given in 0.5 mg tablets. This nurse documented the conversation, and called the physician to advise him. At 14:45, the dose of Clonazepam (Klonopin) was changed to 0.5 mg daily. At 14:00 that day, the patient took 0.5 mg of Clonazepam (Klonopin). Later that day, the patient's husband brought in the actual prescribed medication bottle, and the order was again changed to Clonazepam (Klonopin) 0.5 mg daily as needed to sleep as was indicated by this prescription.

18. The patient could have been sedated by the medication dose administered by Respondent, as it was five times the actual prescribed dose. Over sedation can interfere with

effective ventilation and oxygenation which may have had a very serious detrimental impact on this patient, especially in light of her hospital admission for pneumonia.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 477441, issued to Victoria Reyes Santos;

2. Ordering Victoria Reyes Santos to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: January 19, 2013

for LOUISE R. BAILEY, M.Ed., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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